

SEVERE INFLUENZA CASE HISTORY FORM (ICU AND FATAL CASES AGE 0-64 YEARS)

REQUIRED INFORMATION

CASE STATUS (check all that apply)

- ☐ ICU A case with laboratory-confirmed influenza hospitalized ≥ 24 hours and requiring admission to an intensive care unit (ICU)
- ☐ Fatal A case with laboratory-confirmed influenza that has died at any location (e.g. hospital, emergency, home)

PATIENT INFORMATION

Last name		First name		Date of birth / /	
Street address		City	Zip code	Local health jurisdiction of residence	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

ONSET, HOSPITALIZATION AND DEATH INFORMATION

Date of onset of symptoms / /		Hospitalized ≥ 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If hospitalized, hospital name and location	
Date of hospital admission / /		Date of hospital discharge / /			
If died, date of death / /		If died, location of death (i.e. home, ED-name of hospital ED, etc.)			If died, autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)

Date of specimen collection / /		Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)			
Influenza type and/or subtype <input type="checkbox"/> B <input type="checkbox"/> A – rapid test, culture or DFA positive only <input type="checkbox"/> A – PCR positive, subtyping not done <input type="checkbox"/> A (H3) <input type="checkbox"/> A (2009 H1N1) <input type="checkbox"/> A – PCR positive, unsubtypeable (i.e. novel)					Where was testing performed?

REPORTING AGENCY INFORMATION

Reporting local health jurisdiction	Name of reporter	Telephone number of reporter
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OPTIONAL INFORMATION (Completion of this section is optional. If available, this information helps CDPH greatly in assessing new risk groups and revision of antiviral and vaccine guidances. Please attach relevant medical records if available.)

CLINICAL COURSE

Received antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Type of antiviral <input type="checkbox"/> Oseltamivir <input type="checkbox"/> Zanamivir <input type="checkbox"/> Other Specify other: _____		
Date antiviral treatment started / /		Date antiviral treatment ended / /		Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Complications <input type="checkbox"/> Pneumonia <input type="checkbox"/> ARDS <input type="checkbox"/> Sepsis <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Required vasopressor <input type="checkbox"/> Required hemodialysis <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Secondary bacterial infection If yes, specify organism: _____ <input type="checkbox"/> Other Specify other: _____				

SIGNIFICANT PAST MEDICAL HISTORY

- ☐ Cardiac disease ☐ Chronic pulmonary disorder ☐ Immunosuppression (e.g. cancer) ☐ Immunosuppressive medications (e.g. chemotherapy, steroids)
- ☐ Metabolic disorder (e.g. diabetes mellitus, renal) ☐ Neurological disorder (e.g. cerebral palsy) ☐ Hemoglobinopathy (e.g. sickle cell disease)
- ☐ Genetic disorder (e.g. Downs) ☐ Obesity If obese, BMI (if known): ____ Height: ____ Weight: ____
- ☐ Pregnant If pregnant, estimated delivery date: ____/____/____
- ☐ Postpartum If postpartum, delivery date: ____/____/____ ☐ Other conditions (e.g. hypertension, hyperlipidemia)
- If yes for any of the above, please specify: _____

NOTES SECTION